

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045930

Facility Name: TOWERHILL CARE CENTER

Address: 759 KANE STREET SOUTH ELGIN 60177  
Number City Zip Code

County: KANE

Telephone Number: (847) 697-3310 Fax #: (847) 697-3354

IDPA ID Number: 721525738001

Date of Initial License for Current Owners: 10/25/02

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Steve Lavenda Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax #: (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>206</u>	Skilled (SNF)	<u>206</u>	<u>37,904</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>206</u>	TOTALS	<u>206</u>	<u>37,904</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>22</u>	<u>248</u>	<u>822</u>	<u>1,092</u>	8
9	SNF/PED					9
10	ICF	<u>14,588</u>	<u>4,567</u>		<u>19,155</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,610</u>	<u>4,815</u>	<u>822</u>	<u>20,247</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.42%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 07/01/02

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 07/01/02 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 20 and days of care provided 1,150

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **TOWERHILL CARE CENTER** # **0045930** Report Period Beginning: **07/01/02** Ending: **12/31/02**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	124,292	17,383	1,487	143,162		143,162	(940)	142,222			1
2	Food Purchase		111,929		111,929		111,929	(265)	111,664			2
3	Housekeeping	78,716	36,406		115,122		115,122		115,122			3
4	Laundry	45,119	16,361		61,480		61,480		61,480			4
5	Heat and Other Utilities			57,785	57,785		57,785	1,205	58,990			5
6	Maintenance	16,724	27,161	11,444	55,329		55,329	1,147	56,476			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	264,851	209,240	70,716	544,807		544,807	1,147	545,954			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	859,758	37,506	11,500	908,764		908,764	(1,999)	906,765			10
10a	Therapy			12,285	12,285		12,285		12,285			10a
11	Activities	37,930	4,036		41,966		41,966		41,966			11
12	Social Services	12,481		557	13,038		13,038		13,038			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	910,169	41,542	24,342	976,053		976,053	(1,999)	974,054			16
	<b>C. General Administration</b>											
17	Administrative	33,869		12,000	45,869		45,869	48,770	94,639			17
18	Directors Fees											18
19	Professional Services			38,213	38,213		38,213	(23,494)	14,719			19
20	Dues, Fees, Subscriptions & Promotions			9,964	9,964		9,964	(4,918)	5,046			20
21	Clerical & General Office Expenses	160,781	1,619	32,047	194,447		194,447	13,488	207,935			21
22	Employee Benefits & Payroll Taxes			167,303	167,303		167,303		167,303			22
23	Inservice Training & Education											23
24	Travel and Seminar			510	510		510	5	515			24
25	Other Admin. Staff Transportation			15,181	15,181		15,181	288	15,469			25
26	Insurance-Prop.Liab.Malpractice			12,882	12,882		12,882	792	13,674			26
27	Other (specify):*							8,101	8,101			27
28	<b>TOTAL General Administration</b>	194,650	1,619	288,100	484,369		484,369	43,032	527,401			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,369,670	252,401	383,158	2,005,229		2,005,229	42,180	2,047,409			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			25,631	25,631		25,631	37,567	63,198			30
31	Amortization of Pre-Op. & Org.							6,574	6,574			31
32	Interest			10,029	10,029		10,029	199,937	209,966			32
33	Real Estate Taxes			73,326	73,326		73,326	2,654	75,980			33
34	Rent-Facility & Grounds			301,013	301,013		301,013	(301,013)				34
35	Rent-Equipment & Vehicles			4,057	4,057		4,057	783	4,840			35
36	Other (specify):*											36
37	TOTAL Ownership			414,056	414,056		414,056	(53,498)	360,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,021	114,094	152,115		152,115		152,115			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,856	56,856		56,856		56,856			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		38,021	170,950	208,971		208,971		208,971			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,369,670	290,422	968,164	2,628,256		2,628,256	(11,318)	2,616,938			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,439)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(265)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18)	21		18
19	Entertainment				19
20	Contributions	(1,050)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,622)	21		24
25	Fund Raising, Advertising and Promotional	(733)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,486)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,613)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	26,295		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 26,295		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (11,318)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
TOWERHILL CARE CENTER		
ID#	0045930	
Report Period Beginning:	07/01/02	
Ending:	12/31/02	
		Sch. V Line
NON-ALLOWABLE EXPENSES		
	Amount	Reference
1 BLDG PART BANK CHARGES	\$ (138)	21 1
2 BLDG PART ACCTG FEES	(623)	19 2
3 BLDG PART TRUST FEES	(59)	21 2
4 BLDG PART REPLACEMENT TAX	(1,858)	21 4
5 VETERANS EXPENSE - PHARMACY	(510)	10 5
6 BANK SERVICE CHARGES	(305)	21 6
7 TRUST FEES	(159)	21 7
8 COPE - IC LTC	(3,179)	20 8
9 LEGAL - NON-ALLOW	(3,835)	19 9
10 R.O. BANK CHARGE	(25)	21 10
11 R.O. REPLACEMENT CHARGE	(613)	21 11
12		12
13		13
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95		95
96		96
97		97
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99		99
100		100
101 Total	(10,486)	101







## VII. RELATED PARTIES

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

[illegible]

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ **X** YES ☐ NO

**If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.**

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 301,013	KANE STREET ASSOCIATES	100.00%	\$	(301,013)	1
2	V	32	MORTGAGE INTEREST		KANE STREET ASSOCIATES	100.00%	198,922	198,922	2
3	V	21	BANK CHARGES		KANE STREET ASSOCIATES	100.00%	138	138	3
4	V	19	ACCOUNTING FEES		KANE STREET ASSOCIATES	100.00%	623	623	4
5	V	21	TRUST FEES		KANE STREET ASSOCIATES	100.00%	50	50	5
6	V	21	REPLACEMENT TAX		KANE STREET ASSOCIATES	100.00%	1,058	1,058	6
7	V	30	DEPRECIATION EXPENSE		KANE STREET ASSOCIATES	100.00%	54,689	54,689	7
8	V	31	AMORTIZATION LOAN CTS		KANE STREET ASSOCIATES	100.00%	6,574	6,574	8
9	V	21	INSURANCE		KANE STREET ASSOCIATES	100.00%	7,460	7,460	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 301,013			\$ 269,514	\$ * (31,499)	14

**\* Total must agree with the amount recorded on line 34 of Schedule VI.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 1,205	\$ 1,205	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	1,147	1,147	16
17	V	17	CHIEF FINANCIAL OFFICER		S.W. MANAGEMENT	100.00%	11,260	11,260	17
18	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	341	341	18
19	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	44	44	19
20	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	33,723	33,723	20
21	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	5	5	21
22	V	25	TRANSPORTATION		S.W. MANAGEMENT	100.00%	288	288	22
23	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	792	792	23
24	V	27	PAYROLL TAXES		S.W. MANAGEMENT	100.00%	6,622	6,622	24
25	V	30	DEPRECIATION		S.W. MANAGEMENT	100.00%	1,317	1,317	25
26	V	32	INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	1,015	1,015	26
27	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	2,654	2,654	27
28	V	35	AUTO LEASE		S.W. MANAGEMENT	100.00%	783	783	28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT	100.00%	37,510	37,510	30
31	V	17	SALARY - RONNIE KLEIN		S.W. MANAGEMENT	100.00%			31
32	V	27	EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT	100.00%	1,479	1,479	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT	100.00%			33
34	V								34
35	V	17	MANAGEMENT FEES		S.W. MANAGEMENT	100.00%			35
36	V	19	HOME OFFICE FEES	20,000	S.W. MANAGEMENT	100.00%		(20,000)	36
37	V								37
38	V								38
39	Total			\$ 20,000			\$ 100,185	\$ * 80,185	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	\$ 9,395	S & E MEDICAL SUPPLY	100.00%	\$ 8,456	\$ (940)	15
16	V	10	MEDICAL SUPPLIES	7,447	S & E MEDICAL SUPPLY	100.00%	5,957	(1,489)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 16,842			\$ 14,413	\$ * (2,429)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENTAL INCOME	\$ 200,507	FOX VALLEY HEALTHCARE INC	100.00%	\$	\$ (200,507)	15
16	V	21	OPTION DEPOSIT INCOME	20,600	FOX VALLEY HEALTHCARE INC	100.00%		(20,600)	16
17	V	21	BANK SERVICE CHARGE		FOX VALLEY HEALTHCARE INC	100.00%	25	25	17
18	V	34	LEASE EXPENSE		FOX VALLEY HEALTHCARE INC	100.00%	200,507	200,507	18
19	V	21	STATE REPLACEMENT TAX		FOX VALLEY HEALTHCARE INC	100.00%	613	613	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 221,107			\$ 201,145	\$ * (19,962)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	President	Administrative	42.50%	See Attached	3.5	5.84%	Alloc SW Mgt	\$ 37,510	17-7	1
2	ROSEMARY BETZ	Administratiave Clst	Administrative	10.00%	See Attached	2	4.77%	Fees Facility	12,000	17-3	2
3	MO HERMAN	CFO	Financial	5.00%	See Attached	3.1	7.75%	Alloc SW Mgt	11,260	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,770		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_\_  
Fax Number (\_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER# 0045930

Report Period Beginning:

07/01/02Ending: 12/31/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

S.W. MANAGEMENT

Street Address

7434 N. SKOKIE BLVD.

City / State / Zip Code

SKOKIE, IL. 60077

Phone Number

( 847) 982-2300

Fax Number

( 847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	Available Bed Days	488,314	8	\$ 15,521	\$ 37,904	37,904	1,205	1
2	6	REPAIRS AND MAINT.	Available Bed Days	488,314	8	14,771	37,904	37,904	1,147	2
3	17	CHIEF FINANCIAL OFFICER	Available Bed Days	488,314	8	145,056	145,056	37,904	11,260	3
4	19	PROFESSIONAL FEES	Available Bed Days	488,314	8	4,393	37,904	37,904	341	4
5	20	FEES, SUBSCRIPTIONS, DUES	Available Bed Days	488,314	8	572	37,904	37,904	44	5
6	21	CLERICAL AND GENERAL	Available Bed Days	488,314	8	434,445	380,978	37,904	33,723	6
7	24	EDUCATION AND SEMINARS	Available Bed Days	488,314	8	59	37,904	37,904	5	7
8	25	TRANSPORTATION	Available Bed Days	488,314	8	3,708	37,904	37,904	288	8
9	26	INSURANCE - PROPERTY	Available Bed Days	488,314	8	10,197	37,904	37,904	792	9
10	27	PAYROLL TAXES	Available Bed Days	488,314	8	85,313	37,904	37,904	6,622	10
11	30	DEPRECIATION	Available Bed Days	488,314	8	16,972	37,904	37,904	1,317	11
12	32	INTEREST EXPENSE	Available Bed Days	488,314	8	13,072	37,904	37,904	1,015	12
13	33	REAL ESTATE TAXES	Available Bed Days	488,314	8	34,195	37,904	37,904	2,654	13
14	35	AUTO LEASE	Available Bed Days	488,314	8	10,092	37,904	37,904	783	14
15										15
16	17	SALARY - SHELDON WOLFE	Avg. Hours Worked	60	9	643,036	643,036		37,510	16
17	17	SALARY - RONNIE KLEIN	Avg. Hours Worked	60	7	60,000	60,000			17
18	27	EMP. BEN.-SHELDON WOLFE	Avg. Hours Worked	60	9	25,346			1,479	18
19	27	EMP. BEN.-RONNIE KLEIN	Avg. Hours Worked	60	7	8,354				19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,525,102	\$ 1,229,070		\$ 100,185	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S & E MEDICAL SUPPLY  
Street Address 3100 COMMERCIAL AVENUE  
City / State / Zip Code NORTHBROOK, ILLINOIS 60062  
Phone Number ( 847) 982-9300  
Fax Number (

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	DIETARY SUPPLEMENTS	Direct Allocation						8,456	1
	2	MEDICAL SUPPLIES	Direct Allocation						5,957	2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		14,413	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TOWERHILL CARE CENTER # 0045930 Report Period Beginning: 07/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	KANE STREET ASSOCIATES	X		Mortgage Loan			\$	4,280,936			\$	198,922	1	
2			X	Note Payable - Auto				42,236					2	
3													3	
4													4	
5													5	
	Working Capital													
6	STOCKHOLDERS LOAN		X	Working Capital				800,000				10,029	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	5,123,172				\$	208,951	9
	B. Non-Facility Related*													
10	See Supplemental Schedule											1,015	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	1,015	14
15	TOTALS (line 9+line14)						\$	5,123,172				\$	209,966	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)    SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
1	ALLOC. SW MGMT	X					\$		\$			\$	1,015	1
2														2
3														3
4														4
5														5
6														6
7														7
8														8
9														9
10														10
11														11
12														12
13														13
14														14
15														15
16														16
17														17
18														18
19														19
20														20
21							\$		\$			\$	1,015	21

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.

\$	23,200	1
----	--------	---

\$	2,654	2
----	-------	---

\$	(20,546)	3
----	----------	---

\$	96,526	4
----	--------	---

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$ 5

\_\_\_\_\_

**TOTAL REFUND \$** **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**

\$ 6

\$	75,980	7
----	--------	---

Real Estate Tax Bill for Calendar Year:

1997	8
1998	9
1999	10
2000	11
2001	12

**FOR OHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
----	-----------------------------------	----	----

14	PLUS APPEAL COST FROM LINE 5	\$	14
----	------------------------------	----	----

**A CHANGE OF OWNERSHIP OCCURRED EFF. 7.1.2002. THEREFORE, THE FACILITY IS NOT RESPONSIBLE FOR ANY OF THE R.E. TAXES FOR 2001. - WE HAVE INCLUDED A COPY OF THE TAX BILL.**

15	LESS REFUND FROM LINE 6	\$	15
----	-------------------------	----	----

**ALLOC SW MGMT \$2,654 on Ln 2 above**

16	AMOUNT TO USE FOR RATE CALCULATION \$	16
----	---------------------------------------	----

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

TOWERHILL CARE CENTER

COUNTY

KANE

FACILITY IDPH LICENSE NUMBER

0045930

CONTACT PERSON REGARDING THIS REPORT

STEVE LAVENDA

TELEPHONE ( 847) 236-1111

FAX #: ( 847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	06-34-228-012	Long Term Care Property	\$ 137,894.90	\$ 137,894.90
2.	10-28-412-049-000	Long Term Care Property	\$ 35,720.85	\$ 2,661.14
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 173,615.75	\$ 140,556.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

TOWERHILL CARE CENTER

COUNTY

KANE

FACILITY IDPH LICENSE NUMBER

0045930

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      YES      NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,038

B. General Construction Type: ExteriorFrameNumber of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: \$95,324 - Refinancing costs for Bldg Part.

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 6,574

4. Dates Incurred: 2002

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		2002	\$ 150,000	1
2					2
3	TOTALS			\$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		4,300,576	55,780		56,074	294	927,919	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 4,300,576	\$ 55,780		\$ 56,074	\$ 294	\$ 927,919	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,300,576	\$ 55,780		\$ 56,074	\$ 294	\$ 927,919	1
2	NURSING STATIONS	2002	10,000		20	500	500	500	2
3	CARPET	2002	3,239		20	39	39	39	3
4	TIME RECORDER	2002	6,505		20	651	651	759	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,320,320	\$ 55,780		\$ 57,264	\$ 1,484	\$ 929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,320,320	\$ 55,780		\$ 57,264	\$ 1,484	\$ 929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,320,320	\$ 55,780		\$ 57,264	\$ 1,484	\$ 929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,320,320	\$ 55,780		\$ 57,264	\$ 1,484	\$ 929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,320,320	\$ 55,780		\$ 57,264	\$ 1,484	\$ 929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,320,320	\$55,780		\$57,264	\$1,484	\$929,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	206		2002		\$ 4,233,654	\$ 54,042	39	\$ 54,042	\$	\$ 909,148	4
5											5
6			1995		33,527	860	39	958	98	7,333	6
7											7
8											8
	Improvement Type**										
9											9
10	ALLOC. SW MGMT		1995		3,584	120	20	214	94	1,590	10
11	ALLOC. SW MGMT		1996		626	16	20	31	15	205	11
12	ALLOC. SW MGMT		1997		901	35	20	65	(30)	340	12
13	ALLOC. SW MGMT		1998		621	16	20	31	15	147	13
14	ALLOC. SW MGMT		1999		1,723	44	20	86	42	266	14
15											15
16	ALLOC. KANE STREET STREET ASSOC. BLDG		1991		11,100	276	20	276		3,982	16
17	ALLOC. KANE STREET STREET ASSOC. BLDG		1992		14,840	371	20	371		4,908	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total  
SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,300,576	\$ 55,780		\$ 56,074	\$ 234	\$ 927,919	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 8,331	\$ 100	\$ 690	\$ 590	10	\$ 5,945	71
72	Current Year Purchases	641,355	18,097	1,321	(16,776)	10	1,347	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 649,686	\$ 18,197	\$ 2,011	\$ (16,186)		\$ 7,292	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2002 VOLVO	2002	\$ 39,234	\$ 7,660	\$ 3,923	\$ (3,737)	5	\$ 3,923	76
77										77
78										78
79										79
80	TOTALS			\$ 39,234	\$ 7,660	\$ 3,923	\$ (3,737)		\$ 3,923	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,159,240	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,637	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,198	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,439)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 940,432	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 TOYOTA	\$ 588.93	\$ 4,057	17
18	Alloc. SW Mgmt			783	18
19					19
20					20
21	TOTAL		\$ 588.93	\$ 4,840	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3		4	
		Facility							
		Drop-outs	Completed	Contract	Total				
1	Community College Tuition	\$	\$	\$	\$				
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$	\$	\$	\$				
10	SUM OF line 9, col. 1 and 2 (e)	\$							

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	40,149	\$		\$	40,149	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				22,448				22,448	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				51,497				51,497	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					34,064			34,064	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify): See Supplemental							3,957			3,957	13
14	TOTAL			\$		\$	114,094	\$	38,021	\$	152,115	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 215,596	\$ 216,117	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,080,570	1,080,570	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,132	22,132	6
7	Other Prepaid Expenses	5,660	5,660	7
8	Accounts Receivable (owners or related parties)	14,724	14,724	8
9	Other(specify): See Supplemental Schedule	24,582	75,153	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,363,264	\$ 1,414,356	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		4,233,654	14
15	Leasehold Improvements, at Historical Cost		25,940	15
16	Equipment, at Historical Cost	85,257	703,257	16
17	Accumulated Depreciation (book methods)	(25,631)	(1,561,669)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		95,324	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 59,626	\$ 3,646,506	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,422,890	\$ 5,060,862	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 201,146	\$ 264,027	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,168	4,168	28
29	Short-Term Notes Payable	842,236	842,236	29
30	Accrued Salaries Payable	115,774	115,774	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,802	8,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,526	96,526	32
33	Accrued Interest Payable	3,272	3,272	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Supplemental Schedule	359,029	461,507	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,630,953	\$ 1,796,312	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,280,936	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Supplemental Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,280,936	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,630,953	\$ 6,077,248	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (208,063)	\$ (1,016,386)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,422,890	\$ 5,060,862	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(228,259)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	20,196	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (208,063)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (208,063)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,296,237	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,296,237	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,443	6
7	Oxygen	6,317	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 103,760	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,399,997	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	544,807	31
32	Health Care	976,053	32
33	General Administration	484,369	33
	<b>B. Capital Expense</b>		
34	Ownership	414,056	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	152,115	35
36	Provider Participation Fee	56,856	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,628,256	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(228,259)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (228,259)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number TOWERHILL CARE CENTER

# 0045930

Report Period Beginning:

07/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	804	846	\$ 32,562	\$ 38.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,296	1,764	416,841	236.30	3
4	Licensed Practical Nurses	2,850	3,247	54,694	16.84	4
5	Nurse Aides & Orderlies	26,950	28,208	355,661	12.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,087	4,305	37,930	8.81	10
11	Social Service Workers	492	504	12,481	24.76	11
12	Dietician					12
13	Food Service Supervisor	942	966	21,029	21.77	13
14	Head Cook	2,305	2,694	37,028	13.74	14
15	Cook Helpers/Assistants	8,583	9,030	66,235	7.33	15
16	Dishwashers					16
17	Maintenance Workers	1,010	1,130	16,724	14.80	17
18	Housekeepers	8,922	9,633	78,716	8.17	18
19	Laundry	5,139	5,472	45,119	8.25	19
20	Administrator	960	1,000	33,869	33.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,398	7,773	160,781	20.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	86,738	76,572	\$ 1,369,670 *	\$ 17.89	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	30	\$ 1,487	01-03	35
36	Medical Director				36
37	Medical Records Consultant	39	1,935	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	17	844	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	273	12,285	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	557	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	375	\$ 17,108		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	250	\$ 8,721	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	250	\$ 8,721		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
JEREMY AMSTER	Administrator	0	\$ 33,869	Workers' Compensation Insurance	\$	44,235	IDPH License Fee	\$
				Unemployment Compensation Insurance		2,150	Advertising: Employee Recruitment	1,897
				FICA Taxes		104,780	Health Care Worker Background Check	
				Employee Health Insurance		10,796	(Indicate # of checks performed 12 )	144
				Employee Meals			ICLTC	2,106
				Illinois Municipal Retirement Fund (IMRF)*			DUES & SUBSCRIPTIONS	446
				MISC. EMPLOYEE BENEFITS		1,615		
				HOLIDAY EXPENSE		3,727	LICENSES & PERMITS	410
TOTAL (agree to Schedule V, line 17, col. 1)							Alloc. SW Mgmt	44
(List each licensed administrator separately.)								
B. Administrative - Other							Less: Public Relations Expense	( )
Description			Amount				Non-allowable advertising	( )
ROSE BETZ - MANAGEMENT FEES			\$ 12,000				Yellow page advertising	( )
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	167,303		
(Attach a copy of any management service agreement)				line 22, col.8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Winston & Strawn	Legal		\$ 3,835				Out-of-State Travel	\$
SW Mgmt	Home Office		20,000					
Personnel Planners, Inc.	Unemployment Cslt		1,055					
FR&R	Accounting		13,323				In-State Travel	
							Seminar Expense	510
							Alloc. SW Mgmt	5
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)					\$		line 24, col. 8)	
			\$ 38,213				TOTAL	\$ 515

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	NA		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		TOWERHILL CARE CENTER		STATE OF ILLINOIS				Page 23
		#	0045930	Report Period Beginning:	07/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

YES  
ILC-LTC - \$5,284

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

YES  
YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

YES  
10 YRS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$  
Line N/A

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

NO

(9)

Are you presently operating under a sublease agreement?

YES  
X  
NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES  
NO  
X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$  
56,856

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)  
If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$  
N/A  
Indicate the amount. \$

(16)

Travel and Transportation  
a. Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.  
c. What percent of all travel expense relates to transportation of nurses and patients?  
d. Have vehicle usage logs been maintained?  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

NO  
N/A  
None  
N/A  
YES  
YES

g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

NO  
\$

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

NO

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees

N/A

SEE ACCOUNTANTS' COMPILATION REPORT